

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in item 18. Give Pages 1 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
10022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>		c. LENGTH OF STAY IN Tb <b>Instant</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b>		d. STREET ADDRESS <b>Old Denton Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 404 near Andersontown</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>Brodes</b>		4. DATE OF DEATH Month <b>September</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 17, 1894</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>64</b> Days <b>18</b> Hours <b>19</b> Min. <b>58</b>	IF UNDER 24 HRS. Months <b>64</b> Days <b>18</b> Hours <b>19</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Automobile Garage</b>	
11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Brodes</b>		14. MOTHER'S MAIDEN NAME <b>Anna Fisher</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>213-03-9723</b>	
17. INFORMANT <b>Mrs. John J. Toth, Federalsburg, Md., R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>8975-</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dawson O. George</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dawson O. George, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9-19-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 21, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Framptom and Son, Federalsburg, Maryland</b>		ADDRESS <b>Federalsburg, Maryland</b>	
24a. REC'D BY REGISTRAR <b>SEP 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
Date of Death		Place of Death		Cause of Death	
Occupation		Usual Residence		Manner of Death	
Time of Death		Physician		Medical History	
Post-mortem Examination		Toxicology		Microscopic Examination	
Burial		Disposition of Body		Remarks	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10023  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

10016

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Marydel</b>		c. LENGTH OF STAY IN 1b <b>83 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Daniels</b> Last <b>Daniels</b>		4. DATE OF DEATH Month <b>9</b> Day <b>14</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/12/1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>83</b> Days <b>14</b> Hours <b>19</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>? Daniels</b>		14. MOTHER'S MAIDEN NAME <b>Adeline Daniels</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-16-9033</b>	
17. INFORMANT <b>Julia Daniels Marydel, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Dis.</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 6, 1958</b> , to <b>Sept. 14, 1958</b> , that I last saw the deceased alive on <b>Sept. 14, 1958</b> , and that death occurred at <b>1.30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Stonesifer, M.D.</b>		ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b> DATE SIGNED <b>9/17/58</b>	
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/18/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion</b>		22d. LOCATION (City, town, or county) (State) <b>Rural Marydel, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie, Greensboro, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>SEP 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneel</b>	



## CERTIFICATE OF DEATH

10017

Reg. Dist. No.

10024

1. PLACE OF DEATH o. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>River Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Evelyn</b> Middle <b>Dickerson</b> Last <b>Dickerson</b>		4. DATE OF DEATH Month <b>September</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 17, 1914</b>
9. AGE (In years lost birthday) <b>44</b> yrs.		IF UNDER 1 YEAR Months <b>44</b> Days <b>44</b> Hours <b>44</b> Min.	IF UNDER 24 HRS. Months <b>44</b> Days <b>44</b> Hours <b>44</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Canning Factory</b>	
11. BIRTHPLACE (State or foreign country) <b>Federalsburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emmett Prattis</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Dickerson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>219-14-4133</b>	
17. INFORMANT <b>Mary E. Francis, Federalsburg, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of breast</b> DUE TO <b>Generalized metastasis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>170x</b> DUE TO (c) <b>12 1/2 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 1, 1956</b> to <b>9/9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>9/9</b> , 19 <b>58</b> , and that death occurred at <b>8:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frank M. Anderson</b> M.D.		ADDRESS (Street, city or town, state) <b>Federalsburg, Md.</b> DATE SIGNED <b>9-11-58</b>	
PHYSICIAN'S NAME (Type) <b>Frank M. Anderson, M.D.</b>		<b>Federalsburg, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Sept. 13, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Federal Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Federalsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 19 '58</b>	
		24b. REGISTRAR'S SIGNATURE <i>Robert L. ...</i>	

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

NAME OF DECEASED <i>John Doe</i>		SEX <i>Male</i>		AGE <i>45</i>		DATE OF BIRTH <i>Jan 15 1857</i>		PLACE OF BIRTH <i>Frederick, Md.</i>	
MARRIAGE <i>Married</i>		EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		RELIGION <i>Methodist</i>		RACE <i>White</i>	
CAUSE OF DEATH <i>Heart Disease</i>		MANNER OF DEATH <i>Natural</i>		PLACE OF DEATH <i>Home</i>		DATE OF DEATH <i>Dec 10 1902</i>		TIME OF DEATH <i>10:30 AM</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		SIGNATURE OF MINISTER <i>Rev. W. B. Jones</i>		SIGNATURE OF CORONER <i>John A. Brown</i>		SIGNATURE OF JURY <i>James C. White</i>		SIGNATURE OF DECEASED <i>John Doe</i>	
TESTIMONY OF PHYSICIAN <i>I certify that the above is a true and correct statement of the facts as stated on the certificate of death.</i>		TESTIMONY OF MINISTER <i>I certify that the above is a true and correct statement of the facts as stated on the certificate of death.</i>		TESTIMONY OF CORONER <i>I certify that the above is a true and correct statement of the facts as stated on the certificate of death.</i>		TESTIMONY OF JURY <i>I certify that the above is a true and correct statement of the facts as stated on the certificate of death.</i>		TESTIMONY OF DECEASED <i>I certify that the above is a true and correct statement of the facts as stated on the certificate of death.</i>	



10025

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>		c. LENGTH OF STAY IN 1b <b>22 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Harmony Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>	
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle Last <b>Hines</b>		4. DATE OF DEATH Month <b>September</b> Day <b>25</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1891</b>
9. AGE (In years last birthday) <b>67</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Day Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Street Work</b>	
11. BIRTHPLACE (State or foreign country) <b>Queenstown, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>213-18-4871</b>	
17. INFORMANT <b>Sadie R. Hall, Preston, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of stomach?</b> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchial</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchial Asthma</b> INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/21, 1951</b> , to <b>9/25, 1958</b> , that I last saw the deceased alive on <b>9/27, 1958</b> , and that death occurred at <b>6:25 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Dr. H. B. Plummer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>DR. H. B. PLUMMER</b> <b>Preston Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 29, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Preston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24. REC'D BY REGISTRAR DATE <b>SEP 30 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

10019

10026

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Denton - Rural</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Near Williston</b>		d. STREET ADDRESS <b>Near Williston</b>	
3. NAME OF DECEASED (Type or print) First <b>Pauline</b> Middle <b>Cohee</b> Last <b>Howard</b>		4. DATE OF DEATH Month <b>September</b> Day <b>4</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 1, 1898</b>
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Linwood Cohee</b>		14. MOTHER'S MAIDEN NAME <b>Effie S. Neal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-24-2334</b>	
17. INFORMANT <b>Alonzo G. Howard, Denton, Maryland, R.F.D.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio Vascular Renal Disease</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> to <b>94</b> , <b>1958</b> , that I last saw the deceased alive on <b>9-4</b> , <b>1958</b> , and that death occurred at <b>3:30P M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Lawson O George</b> M.D. <b>Denton Md</b> <b>9-6-58</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 7, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Denton Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Denton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR <b>SEP 9 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		DATE OF DEATH 4-4-68		PLACE OF DEATH MEMPHIS, TENN.	
AGE 35		SEX M		RACE W	
BIRTH DATE 1-25-33		BIRTH PLACE MOBILE, ALA.		MARRIAGE MARRIED	
OCCUPATION CONGRESSMAN		EDUCATION HIGH SCHOOL		RELIGION METHODIST	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		IMMEDIATE CAUSE CORONARY THROMBOSIS	
MEDICAL HISTORY HYPERTENSION		PREVIOUS ILLNESS NONE		TREATMENT NONE	
SIGNS AND SYMPTOMS PAIN IN CHEST		DIAGNOSIS MYOCARDIAL INFARCTION		PATHOLOGICAL FINDINGS CORONARY Atherosclerosis	
DATE OF EXAMINATION 4-4-68		PLACE OF EXAMINATION MEMPHIS, TENN.		EXAMINER DR. J. H. HARRIS	
SIGNATURE OF DECEASED JAMES EARL RAY		SIGNATURE OF WITNESS DR. J. H. HARRIS		SIGNATURE OF PHYSICIAN DR. J. H. HARRIS	
DATE OF SIGNATURE 4-4-68		DATE OF SIGNATURE 4-4-68		DATE OF SIGNATURE 4-4-68	

State of Maryland

This is to certify that the foregoing is a true and correct copy of the original as filed in the office of the Registrar of Deaths, State of Maryland, on the 4th day of April, 1968.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Ridgely</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Rural Ridgely</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		/d. STREET ADDRESS <b>None</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Katie</b> First <b>Nichols</b> Middle <b>Nichols</b> Last		4. DATE OF DEATH <b>9</b> Month <b>3</b> Day <b>1958</b> Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/2/1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>8</b> Days <b>7</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>8</b> Days <b>7</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>No Record</b>		14. MOTHER'S MAIDEN NAME <b>No Record</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Rosie John's Ridgely, Maryland</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> DUE TO <b>442x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiovascular Renal Disease</b> DUE TO <b>Generalized Arteriosclerosis</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Apr. 10, 1955</b> to <b>Sept. 3, 1958</b> that I last saw the deceased alive on <b>Sept. 2, 1958</b> , and that death occurred on <b>Sept. 3, 1958</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Greensboro, Maryland</b> DATE SIGNED <b>Sept. 4, 1958</b>			
ACTUAL SIGNATURE <b>Charles H. Stonesifer, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/7/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sandtown</b>		22d. LOCATION (City, town, or county) (State) <b>Hillsboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.E. Bouleis, Greensboro, Md.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>SEP 5 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hoad</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10028

## CERTIFICATE OF DEATH

Reg. Dist. No.

10021

1. PLACE OF DEATH o. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greensboro</b>		c. LENGTH OF STAY IN 1b <b>1 Hr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harold</b> First <b>Thurston</b> Middle <b>Smith</b> Last		4. DATE OF DEATH <b>9</b> Month <b>20</b> Day <b>19</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/13/1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Mass.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Cook Smith</b>		14. MOTHER'S MAIDEN NAME <b>Ida MacKinnon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give way or dates of service) <b>W.W.1</b>		16. SOCIAL SECURITY NO. <b>032-10-9186</b>	
17. INFORMANT <b>Edith F. Kotowski</b>		Address <b>Henderson, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular Collapse -</b> <b>540.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastric Hemorrhage</b> (c) <b>Gastric Ulcer</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 hours</b> <b>6 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subtotal Puncture Injury 1955</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 13, 1958</b> to <b>Sept 20, 1958</b> , that I last saw the deceased alive on <b>Sept. 20, 1958</b> , and that death occurred at <b>7:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Robert H. Wright</b> M.D.		ADDRESS (Street, city or town, state) <b>MARPLE AVE</b> DATE SIGNED <b>9/23/58</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT H. WRIGHT, M.D.</b>		<b>GREENSBORO, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/23/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>		22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaire</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	





10029

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Caroline</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalburg</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Academy Avenue</b>				d. STREET ADDRESS <b>Academy Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>Homer</b> Last <b>Turner</b>				4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 15, 1874</b>	
9. AGE (In years lost birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months <b>5</b> Days <b>mon</b>		IF UNDER 24 HRS. Hours <b>1</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Masonry Contractor</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>East New Market, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Samuel Turner</b>				14. MOTHER'S MAIDEN NAME <b>Mary Virginia Carroll</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-6397</b>		17. INFORMANT <b>Mrs. C. Homer Turner, Federalburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma, etiology</b> <b>199.2</b> DUE TO <b>undetermined</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Dehydration &amp; emaciation</b> (c) <b>1 mon</b>				INTERVAL BETWEEN ONSET AND DEATH <b>5 mon</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-12-58</b> , to <b>9-14-58</b> , that I last saw the deceased alive on <b>9-9-58</b> , and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>R. Kingsbury</b>				DATE SIGNED <b>Seaford, Delaware</b>			
ACTUAL SIGNATURE				M.D.			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 16, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hill Crest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Federalburg, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 19 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES M. WOOD		DATE OF BIRTH JAN 15 1880		PLACE OF BIRTH BALTIMORE, MARYLAND	
MARRIAGE MARRIED		DATE OF MARRIAGE JUN 15 1905		PLACE OF MARRIAGE BALTIMORE, MARYLAND	
EDUCATION HIGH SCHOOL		OCCUPATION CLOCK MAKER		RESIDENCE 1234 E. BALTIMORE ST.	
RELIGION METHODIST		MANNER OF DEATH SUICIDE		CAUSE OF DEATH FIRE	
DATE OF DEATH JUN 15 1905		PLACE OF DEATH BALTIMORE, MARYLAND		AGE 25 YEARS	
SEX MALE		COLOR WHITE		HEIGHT 5 FT 10 IN	
WEIGHT 160 LBS		TEMPERATURE 98.6 F		PULSE 72	
BLOOD PRESSURE 120/80		RESPIRATION 18		DIGESTION GOOD	
URINARY NORMAL		GENITAL NORMAL		SKIN NORMAL	
MIND NORMAL		SLEEP NORMAL		FEEDING NORMAL	
DRESSING NORMAL		CARE NORMAL		COMFORT NORMAL	
PAIN NONE		FEBRILE NONE		PROGNOSIS FAVORABLE	
TREATMENT NONE		NURSING NORMAL		DIET NORMAL	
MEDICATION NONE		SURGERY NONE		PATHOLOGY NONE	
LABORATORY NONE		RADIOLOGY NONE		HISTOLOGY NONE	
MICROBIOLOGY NONE		IMMUNOLOGY NONE		TOXICOLOGY NONE	
PHARMACOLOGY NONE		PSYCHOLOGY NONE		PSYCHIATRY NONE	
NEUROLOGY NONE		ENTOMOLOGY NONE		BOTANY NONE	
ZOOLOGY NONE		GEOLOGY NONE		ASTRONOMY NONE	
METEOROLOGY NONE		CLIMATE NONE		SOIL NONE	
WATER NONE		AIR NONE		FIRE NONE	
EARTH NONE		COSMOS NONE		UNIVERSE NONE	

RECEIVED  
JUN 15 1905  
BALTIMORE, MARYLAND

10030

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Greensboro</b>		c. LENGTH OF STAY IN 1b <b>45 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Wheeler</b>		4. DATE OF DEATH Month <b>9</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/20/1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Delaware</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Wheeler</b>	
14. MOTHER'S MAIDEN NAME <b>No Record</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>212-18-6123</b>		17. INFORMANT Address <b>Ida Wheeler Greensboro, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Prostate with metastasis to bladder</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>177X</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 2, 1958</b> to <b>Sept. 18, 1958</b> , that I lost sowed the deceased olive on <b>Sept. 17, 1958</b> , and that death occurred at <b>8 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Greensboro, Md.</b> DATE SIGNED <b>9/19/58</b>			
ACTUAL SIGNATURE <b>Charles H. Stonesifer</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles H. Stonesifer, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/21/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Greensboro</b>	22d. LOCATION (City, town, or county) (State) <b>Greensboro, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaie</b>		ADDRESS <b>Greensboro, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 23 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10153

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

10153

Name of Deceased		Date of Death	
John J. Thompson		April 1, 1911	
Age		Sex	
65		Male	
Race		Color	
White		White	
Place of Birth		Usual Residence	
Maryland		Baltimore, Md.	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Died at		Place of Death	
Home		Baltimore, Md.	
Signature of Physician		Signature of Registrar	
J. J. Thompson		J. J. Thompson	
Date of Signature		Date of Signature	
April 1, 1911		April 1, 1911	

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 have been filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10031  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
CERTIFICATE OF DEATH

10024

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Choptank</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston - Rural</b>	
3. NAME OF DECEASED (Type or print) First <b>Nellie</b> Middle <b>Cleveland</b> Last <b>Wright</b>		4. DATE OF DEATH Month <b>September</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 8, 1887</b>
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Caroline Co., Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William T. Blades</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Dukes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-05-7230</b>	
17. INFORMANT Address <b>Mrs. John W. Smith, Honeybrook, Pa.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Decompensation</b> <b>151X</b> DUE TO <b>Generalized Carcinomatosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of stomach</b> (c) <b>Parkinson's Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>8 months</b> <b>18 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 21</b> , 19 <b>58</b> to <b>Sept 22</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Sept 21</b> , 19 <b>58</b> , and that death occurred at <b>4:15 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Lawrence B. Plummer</b> M.D.			
PHYSICIAN'S NAME (Type) <b>DR. H. B. PLUMMER, Preston Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 25, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Choptank Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Near Preston, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 26 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH April 15, 1950		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Retired		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS Hypertension		14. MEDICATION None		15. PHYSICIAN Dr. J. H. Smith	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)	
19. SIGNATURE OF REGISTRAR (None)		20. SIGNATURE OF CLERK (None)		21. SIGNATURE OF JUDGE (None)	
22. SIGNATURE OF DISTRICT ATTORNEY (None)		23. SIGNATURE OF COUNTY CLERK (None)		24. SIGNATURE OF STATE CLERK (None)	
25. SIGNATURE OF DEPARTMENT CLERK (None)		26. SIGNATURE OF HEALTH COMMISSIONER (None)		27. SIGNATURE OF GOVERNOR (None)	